

# UB-04 CLAIM SUBMISSION

SUBMITTING UB-04 INSTITUTIONAL CLAIMS THROUGH  
THE OHCA SECURE PROVIDER PORTAL



# CLASS DESCRIPTION

This class will provide an in-depth look at the UB-04 institutional claims submission on the secure provider portal. Attendees will learn more about the policy and procedures of submitting Medicaid primary, Medicaid secondary, HMO co-pay and Medicare crossover claims. General coding for services will not be addressed in this presentation.

## Recommended audience:

- Billing staff who submit UB-04 institutional claims.

# DISCLAIMER

- SoonerCare policy is subject to change.
- The information included in this presentation is current as of January 2021.
- Stay informed with current information found on the OHCA public website [www.oklahoma.gov/ohca](http://www.oklahoma.gov/ohca).

# AGENDA

- Claim Basics
- Claim Submission
  - Medicaid Primary
  - Medicaid Secondary
  - HMO Co-pay
  - Medicare Crossover
- Claim Functions
- Resources
- Questions

# CLAIM BASICS

# CLAIM ID NUMBERS

When claims are entered into the SoonerCare provider portal, they are issued a tracking number known as the Internal Control Number (ICN) or the Claim ID number.

- 13-digit number
- Made up of four pieces of identifying information
- Example Claim ID: 2220000606000

# CLAIM ID NUMBERS

ICN Orientation: RRYJJJJIIIIII

- **RR**: The first two digits represent the region code, or the type of claim being processed.
- **YY**: The next two digits refer to the calendar year the claim was received.
- **JJJ**: These three digits refer to the Julian date the claim was received.
- **IIIIII**: The last six digits refer to the claim number assigned when the claim is received.

# CLAIM ID NUMBERS

| Code | Description                           |
|------|---------------------------------------|
| 10   | Paper claims without attachments      |
| 11   | Paper claims with attachments         |
| 20   | Electronic claims without attachments |
| 21   | Electronic claims with attachments    |
| 22   | Internet claims without attachments   |
| 23   | Internet claims with attachments      |
| 49   | Recipient linking claims              |
| 59   | Provider reversals/voids              |
| 91   | Batches requiring manual review       |
| 92   | HMO Copays – paper                    |
| 94   | Web HMO Copays – with attachment      |

Region codes indicate the claim submission method used.

# CLAIM STATUS

Once a claim has adjudicated, it is assigned one of four statuses by the OKMMIS system:

- **Paid** – Claim has paid all or some of the line items.
- **Denied** – Claim is denied either at the header or detail levels.
- **Suspended** – Claim is still in process and may require manual review by a resolutions department.
- **Resubmit** – Claim was received during the system cycle process time but does not need to be resubmitted.

# TIMELY FILING

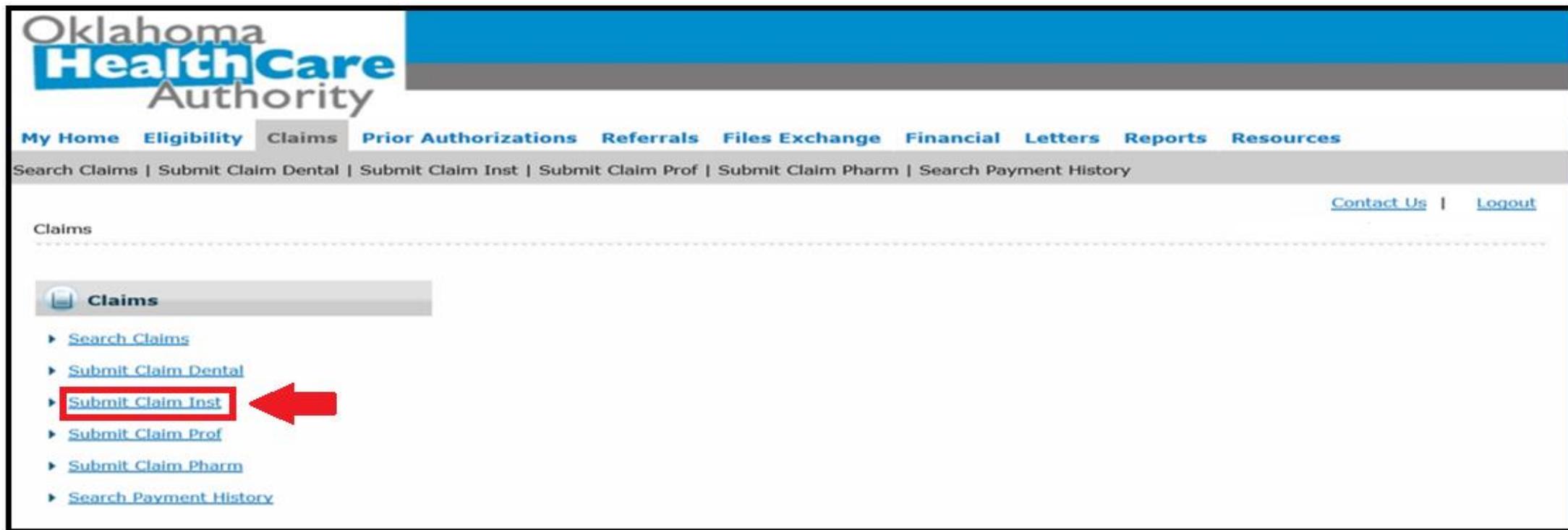
- Claims must be filed within the first six months from the date of service to establish timely filing.
- Proof of timely filing must be attached if a claim is received after six months from the date of service.
- Timely filing proof is considered a claim from the OHCA secure provider portal that reflects the ICN and line-item details or a copy of an OHCA remittance advice with the same information.

# **CLAIM SUBMISSION**

# MEDICAID PRIMARY

- Medicaid is considered primary if it is the member's only source of coverage.
- Medicaid is the payer of last resort.
  - Exceptions to this are Indian Health Services and those eligible for the Crime Victims Compensation Act.
- Providers are reimbursed based on fee schedule allowable rates.

# MEDICAID PRIMARY



Oklahoma HealthCare Authority

My Home Eligibility **Claims** Prior Authorizations Referrals Files Exchange Financial Letters Reports Resources

Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Submit Claim Pharm | Search Payment History

[Contact Us](#) | [Logout](#)

Claims

**Claims**

- ▶ [Search Claims](#)
- ▶ [Submit Claim Dental](#)
- ▶ [Submit Claim Inst](#)
- ▶ [Submit Claim Prof](#)
- ▶ [Submit Claim Pharm](#)
- ▶ [Search Payment History](#)

Select Submit Claim Institutional.

# MEDICAID PRIMARY

**Submit Institutional Claim: Step 1** ?

\* Indicates a required field.

|                   |                      |
|-------------------|----------------------|
| <b>Claim Type</b> | <b>Inpatient</b>     |
|                   | Crossover Inpatient  |
| <b>HCA-17</b>     | Outpatient           |
|                   | Crossover Outpatient |
|                   | Home Health          |
|                   | Long Term Care       |

**Provider Information**

Types of Institutional Claims:

- Inpatient and Outpatient
- Crossover Inpatient and Outpatient
- Home Health
- Long Term Care

Select the appropriate Claim Type.

# MEDICAID PRIMARY

Attending, Operating and Referring Providers are individual provider identifications and are required, if applicable.

- **Operating Provider** is required when billing a surgical procedure.
- **Referring Provider** is required if the member has a Patient Centered Medical Home (PCMH) and the service requires a referral.

Enter the **Member ID** number. The member demographics will auto populate if the ID is valid.

| Provider Information  |                      |          |                      |
|---|----------------------|----------|----------------------|
| If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required. |                      |          |                      |
| Billing Provider ID   | ID Type              | NPI      | Name                 |
| Zip Code  | Contract Code        | Taxonomy | SC Provider Number   |
| Institutional Provider ID   | <input type="text"/> | ID Type  | <input type="text"/> |
| Attending Provider ID   | <input type="text"/> | ID Type  | <input type="text"/> |
| Operating Provider ID   | <input type="text"/> | ID Type  | <input type="text"/> |
| Referring Provider ID   | <input type="text"/> | ID Type  | <input type="text"/> |

| Patient Information   |                      |            |        |
|---|----------------------|------------|--------|
| Enter the Member ID. If Member ID is valid, the rest of the member information will populate. |                      |            |        |
| *Member ID  | <input type="text"/> |            |        |
| Last Name   |                      | First Name | Middle |
| Birth Date  |                      |            |        |

# MEDICAID PRIMARY

## Claim Information:

- Inpatient and crossover inpatient claims require that more specific **Claim Information** be entered.
- Outpatient and crossover outpatient claims require only **Covered Dates** and **Type of Bill** be entered.
- **Other Insurance** needs to be left at *None* when Medicaid is the primary payer.
- Select **Continue** after entering required information.

### Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

|                        |   |                      |                              |
|------------------------|---|----------------------|------------------------------|
| *Covered Dates         | <input type="text" value="12/01/2020"/> - <input type="text" value="12/31/2020"/> | Covered Days         | <input type="text"/>         |
| *Admission Date/Hour   | <input type="text"/> - <input type="text"/> (hh:mm)                               | Discharge Hour       | <input type="text"/> (hh:mm) |
| *Admission Type        | <input type="text"/>  | *Admission Source    | <input type="text"/>         |
| *Admitting ICD Version | ICD-10-CM   | *Admitting Diagnosis | <input type="text"/>         |
| *Patient Status        | <input type="text"/>  | *Type of Bill        | <input type="text"/>         |
| Patient Account Number | <input type="text"/>  | Other Insurance      | None                         |
| HMO Copay              | No  | Total Charged Amount | \$0.00                       |



# MEDICAID PRIMARY

- Diagnosis Code field is required. Enter the diagnosis code without the decimal point and select the **Add** button after each diagnosis.
- Present on Admission is only entered for inpatient claims.

### Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| #        | ICD Version | Diagnosis Code | POA | Action |
|----------|-------------|----------------|-----|--------|
| <u>1</u> |             |                |     |        |

1 \*ICD Version  \*Diagnosis Code

Present on Admission



N-No Diag was not POA  
U-No Information in the record  
W-Clinically Undetermined  
Y-Yes Diag was POA

### Emergency Diagnosis Code

Only one emergency diagnosis code is allowed per claim.

ICD Version  Diagnosis Code

# MEDICAID PRIMARY

Condition Codes, Occurrence Codes and Value Codes are only required if applicable.

- **Condition code** may describe conditions or circumstances surrounding the reason the patient is in a facility.
- **Occurrence code** identifies significant events relating to an institutional claim or encounter record that may affect payer processing. This code is associated with a specific date.
- **Value code** indicates a monetary condition which was used by the intermediary to process an institutional claim. Value Code dollar amount should include cents.

### Condition Codes

Click the **Remove** link to remove the entire row.

| # | Condition Code  | Action |
|---|---|--------|
| 1 |   |        |
| 1 | *Condition Code <input type="text"/>  |        |
|   |  <input type="button" value="Add"/> <input type="button" value="Reset"/> |        |

### Occurrence Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| # | Occurrence Code   | From Date                       | To Date                      | Action |
|---|---|---------------------------------|------------------------------|--------|
| 1 |   | -                               | -                            |        |
| 1 | *Occurrence Code <input type="text"/>   | *From Date <input type="text"/> | To Date <input type="text"/> |        |
|   |  <input type="button" value="Add"/> <input type="button" value="Reset"/> |                                 |                              |        |

### Value Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| # | Value Code  | Amount                       | Action |
|---|---|------------------------------|--------|
| 1 |   |                              |        |
| 1 | *Value Code <input type="text"/>  | *Amount <input type="text"/> |        |
|   |  <input type="button" value="Add"/> <input type="button" value="Reset"/> |                              |        |

# MEDICAID PRIMARY

- Enter the appropriate Revenue Code.
- Enter From and To dates.
- Enter the appropriate Units.
- Charge Amount is the amount billed and must be entered, or claim will deny or pay at \$0.
- Add service details.
- Attachments are required, if applicable.
- Select Submit after all service lines are entered.

### Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| Svc # | Revenue Code | HCPCS/Proc Code | From Date | To Date | Units | Charge Amount | Action |
|-------|--------------|-----------------|-----------|---------|-------|---------------|--------|
| 1     |              |                 |           |         |       |               |        |

1 \*Revenue Code  HCPCS/Proc Code

Modifiers

From Date  To Date  \*Units  \*Unit Type

DMH Contract Source  Charge Amount



### Attachments

Click the **Remove** link to remove the entire row.

| #   | Transmission Method      | File | Control # | Attachment Type | Action  |
|---|--------------------------|------|-----------|-----------------|---|
|  | Click to add attachment. |      |           |                 |  |



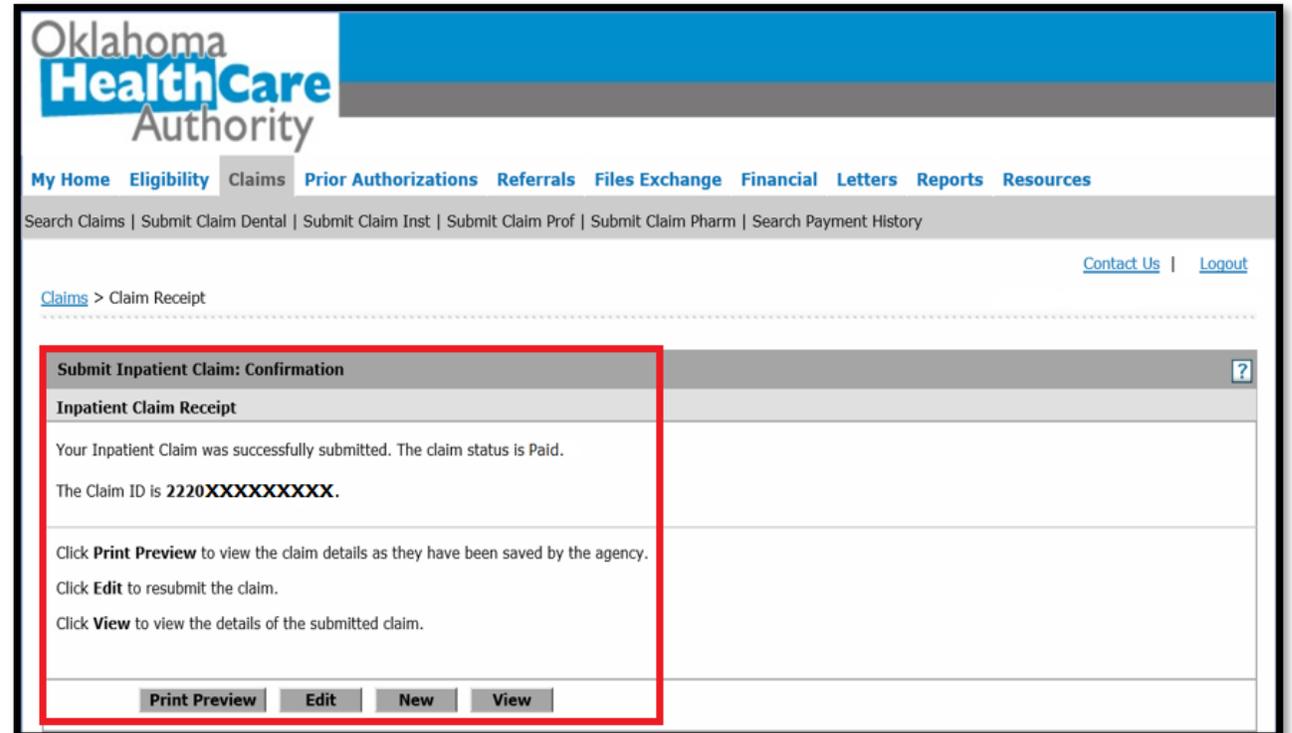
# MEDICAID PRIMARY

- Review the claim to verify the information was entered correctly.
- Information can be changed by selecting **Back to Step 1, 2 or 3**.
- Select **Confirm** to finalize the claim.

| Diagnosis Codes <span>+</span>                  |                        |                 |     |                                |         |                                |   |                               |                        |
|---|------------------------|-----------------|-----|--------------------------------|---------|--------------------------------|---|-------------------------------|------------------------|
| Emergency Diagnosis Code <span>+</span>         |                        |                 |     |                                |         |                                |   |                               |                        |
| Service Details <span>-</span>                  |                        |                 |     |                                |         |                                |   |                               |                        |
| Svc #   | Revenue Code           | HCPCS/Proc Code | Mod | From Date                      | To Date | Units/Type                     | DMH   | Charge Amount                 |                        |
| 1   | 140-ROOM-BOARD/PVT/DLX |                 |     |                                |         | 1.00 Days                      |   | \$250.00                      |                        |
| No Other Insurance Details exist for this claim |                        |                 |     |                                |         |                                |   |                               |                        |
| No Condition Codes exist for this claim         |                        |                 |     |                                |         |                                |   |                               |                        |
| No Occurrence Codes exist for this claim        |                        |                 |     |                                |         |                                |   |                               |                        |
| No Value Codes exist for this claim             |                        |                 |     |                                |         |                                |   |                               |                        |
| No Surgical Procedures exist for this claim     |                        |                 |     |                                |         |                                |   |                               |                        |
| No Attachments exist for this claim             |                        |                 |     |                                |         |                                |   |                               |                        |
| <a href="#">Back to Step 1</a>                  |                        |                 |     | <a href="#">Back to Step 2</a> |         | <a href="#">Back to Step 3</a> |   | <a href="#">Print Preview</a> |                        |
|   |                        |                 |     |                                |         |                                |  | <a href="#">Confirm</a>       | <a href="#">Cancel</a> |

# MEDICAID PRIMARY

- Upon confirmation, the claim will adjudicate, and the claim ID will populate.
- Status is either Paid, Denied, Suspended or Resubmit.
- Claim Options are Print Preview, Edit, New or View.



The screenshot displays the Oklahoma HealthCare Authority website interface. At the top, the logo for the Oklahoma HealthCare Authority is visible. Below the logo, a navigation menu includes links for My Home, Eligibility, Claims, Prior Authorizations, Referrals, Files Exchange, Financial, Letters, Reports, and Resources. A search bar is located below the navigation menu, with options to search for Claims, Submit Claim Dental, Submit Claim Inst, Submit Claim Prof, Submit Claim Pharm, and Search Payment History. On the right side of the page, there are links for Contact Us and Logout. The main content area shows a breadcrumb trail: Claims > Claim Receipt. A red box highlights a confirmation message titled "Submit Inpatient Claim: Confirmation". The message states: "Your Inpatient Claim was successfully submitted. The claim status is Paid. The Claim ID is 2220XXXXXXXX." Below the message, there are instructions: "Click Print Preview to view the claim details as they have been saved by the agency.", "Click Edit to resubmit the claim.", and "Click View to view the details of the submitted claim." At the bottom of the highlighted area, there are four buttons: Print Preview, Edit, New, and View.

# MEDICAID SECONDARY

- Medicaid is considered secondary when other insurance or coverage is responsible for payment.
- SoonerCare members may have other insurance in addition to SoonerCare:
  - A commercial group plan through a member's employer.
  - An individually purchased plan.
  - Insurance available as a result of an accident or injury.

# MEDICAID SECONDARY

- Providers must verify if a member has other insurance prior to services rendered.
- The primary insurance guidelines must be met for SoonerCare to consider payment.
- Providers accept the SoonerCare allowable as payment in full and may not bill the member for any remaining balance.

# MEDICAID SECONDARY

**Submit Institutional Claim: Step 1** ?

\* Indicates a required field.

Claim Type

HCA-17

Choose appropriate Claim Type.

# MEDICAID SECONDARY

Attending, Operating and Referring Providers are individual provider identifications, and are required if applicable.

- **Operating Provider** is required when billing a surgical procedure.

Enter the **Member ID** number. The member demographics will auto populate if the ID is valid.

| Provider Information  |                      |                   |                           |
|---|----------------------|-------------------|---------------------------|
| If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required. |                      |                   |                           |
| <b>Billing Provider ID</b>  | <b>ID Type</b>       | <b>NPI</b>        | <b>Name</b>               |
| <b>Zip Code</b>   | <b>Contract Code</b> | <b>Taxonomy</b>   | <b>SC Provider Number</b> |
| <b>Institutional Provider ID</b>  | <input type="text"/> | <b>ID Type</b>    | <input type="text"/>      |
| <b>Attending Provider ID</b>  | <input type="text"/> | <b>ID Type</b>    | <input type="text"/>      |
| <b>Operating Provider ID</b>  | <input type="text"/> | <b>ID Type</b>    | <input type="text"/>      |
| <b>Referring Provider ID</b>  | <input type="text"/> | <b>ID Type</b>    | <input type="text"/>      |
| Patient Information   |                      |                   |                           |
| Enter the Member ID. If Member ID is valid, the rest of the member information will populate.           |                      |                   |                           |
| <b>*Member ID</b>   | <input type="text"/> |                   |                           |
| <b>Last Name</b>  |                      | <b>First Name</b> | <b>Middle</b>             |
| <b>Birth Date</b>   |                      |                   |                           |

# MEDICAID SECONDARY

If the primary insurance paid:

- Select *Include* under the **Other Insurance** section and **Continue** to step 2.
- After entering the **Diagnosis**, enter the primary insurance **Payer Code** and the amount paid in the **Prior Amount** field.

**Claim Information**

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

|                               |                         |                             |         |
|-------------------------------|-------------------------|-----------------------------|---------|
| <b>*Covered Dates</b>         | 12/01/2020 - 12/04/2020 | <b>Covered Days</b>         |         |
| <b>Admission Date/Hour</b>    |                         | <b>Discharge Hour</b>       |         |
| <b>Admission Type</b>         |                         | <b>Admission Source</b>     |         |
| <b>Admitting ICD Version</b>  | ICD-10-CM               | <b>Admitting Diagnosis</b>  |         |
| <b>Patient Status</b>         |                         | <b>*Type of Bill</b>        | 131     |
| <b>Patient Account Number</b> |                         | <b>Other Insurance</b>      | Include |
| <b>HMO Copay</b>              | No                      | <b>Total Charged Amount</b> | \$0.00  |

 **Continue** **Cancel**

**Diagnosis Codes**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| # | ICD Version            | Diagnosis Code  | Action |
|---|------------------------|-----------------|--------|
| 1 | *ICD Version ICD-10-CM | *Diagnosis Code |        |

 **Add** **Reset**

**Emergency Diagnosis Code**

Only one emergency diagnosis code is allowed per claim.

ICD Version ICD-10-CM **Diagnosis Code**

**Other Insurance Details**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| # | Payer Code  | Prior Amount  | Estimated Amount Due | Action |
|---|-------------|---------------|----------------------|--------|
| 1 | *Payer Code | *Prior Amount | Estimated Amount Due |        |

 **Add** **Reset**

# MEDICAID SECONDARY

If the primary insurance denied or applied to deductible:

- Select *Denied* under the **Other Insurance** section and **Continue** to step 2.
- Enter the **Diagnosis**. Because primary insurance denied, the **Other Insurance** Details are not present.

**Claim Information**

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

\*Covered Dates  -

Admission Date/Hour  (hh:mm) -  (hh:mm)

Admission Type

Admitting ICD Version ICD-10-CM

Patient Status

Patient Account Number

HMO Copay No

Covered Days

Discharge Hour  (hh:mm)

Admission Source

Admitting Diagnosis

\*Type of Bill

Other Insurance **Denied**

Total Charged Amount \$0.00

 **Continue** **Cancel**

**Diagnosis Codes**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| # | ICD Version            | Diagnosis Code                       | Action |
|---|------------------------|--------------------------------------|--------|
| 1 | *ICD Version ICD-10-CM | *Diagnosis Code <input type="text"/> |        |

 **Add** **Reset**

Emergency Diagnosis Code

Condition Codes

Occurrence Codes

Value Codes

Surgical Procedures

**Back to Step 1**  **Continue** **Cancel**

# MEDICAID SECONDARY

Condition Codes, Occurrence Codes and Value Codes are only required if applicable.

- **Condition code** may describe conditions or circumstances surrounding the reason the patient is in a facility.
- **Occurrence code** identifies significant events relating to an institutional claim or encounter record that may affect payer processing. This code is associated with a specific date.
- **Value code** indicates a monetary condition which was used by the intermediary to process an institutional claim. Value Code dollar amount should include cents.

### Condition Codes

Click the **Remove** link to remove the entire row.

| # | Condition Code | Action |
|---|----------------|--------|
| 1 |                |        |

1 \*Condition Code



### Occurrence Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| # | Occurrence Code | From Date | To Date | Action |
|---|-----------------|-----------|---------|--------|
| 1 |                 | -         | -       |        |

1 \*Occurrence Code  \*From Date   To Date



### Value Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| # | Value Code | Amount | Action |
|---|------------|--------|--------|
| 1 |            |        |        |

1 \*Value Code  \*Amount



# MEDICAID SECONDARY

- Enter the appropriate Revenue Code.
- Enter From and To dates.
- Enter the appropriate Units.
- Charge Amount is the amount billed and must be entered or claim will deny or pay at \$0.
- NDC field is present for outpatient and home health claim types and is required if billing a vaccine.
- Add service details.

### Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| Svc # | Revenue Code | HCPCS/Proc Code | From Date | To Date | Units | Charge Amount | Action |
|-------|--------------|-----------------|-----------|---------|-------|---------------|--------|
| 1     |              |                 |           |         |       |               |        |

1 \*Revenue Code  HCPCS/Proc Code

Modifiers

\*From Date  \*To Date  \*Units  \*Unit Type

Charge Amount

NDC for Item 1



# MEDICAID SECONDARY

- The National Drug Code (NDC) information must be entered for vaccine codes.
- Select the + sign to expand the NDC box. Enter the information and select **Add** to save to the line item of service.

NDC for Item 2 

NDC for Item 2 

If applicable, only one NDC/UPN is allowed per service detail line. When adding an NDC/UPN, the Code Type, Quantity and Unit of Measure fields are required.

Code Type NDC

NDC/UPN

Quantity  Unit of Measure



# MEDICAID SECONDARY

- If primary insurance denied or applied payment to the deductible, the EOB must be attached to the claim. Click the + icon to expand the **Attachments** section.
- Choose the **Attachment Type** and **Add** the attachment.
- Select **Submit** after all lines of service and attachments have been entered.

Attachments

Click the **Remove** link to remove the entire row.

| #                          | Transmission Method | File | Control # | Attachment Type | Action |
|----------------------------|---------------------|------|-----------|-----------------|--------|
| + Click to add attachment. |                     |      |           |                 |        |

[Back to Step 1](#) [Back to Step 2](#) [Submit](#) [Cancel](#)

Attachments

Click the **Remove** link to remove the entire row.

Click to collapse.

\*Transmission Method

\*Upload File  [Browse...](#)

\*Attachment Type

Description

[Add](#) [Cancel](#)

[Back to Step 1](#) [Back to Step 2](#) [Submit](#) [Cancel](#)

# MEDICAID SECONDARY

- Review the claim to verify the information was entered correctly.
- Information can be changed by selecting **Back to Step 1, 2** or **3**.
- Select **Confirm** to finalize the claim.

Diagnosis Codes +

Other Insurance was denied for this claim.

Service Details -

| Svc # | Revenue Code               | HCPCS/Proc Code | Mod | From Date  | To Date    | Units/Type | Charge Amount |
|-------|----------------------------|-----------------|-----|------------|------------|------------|---------------|
| 1     | 429-PHYSICAL THERAPY/OTHER |                 |     | 12/08/2020 | 12/08/2020 | 1.00 Unit  | \$500.00      |

No Emergency Diagnosis Code exist for this claim

No Condition Codes exist for this claim

No Occurrence Codes exist for this claim

No Value Codes exist for this claim

No Surgical Procedures exist for this claim

No Attachments exist for this claim

**Back to Step 1** **Back to Step 2** **Back to Step 3** **Print Preview**  **Confirm** **Cancel**

# MEDICAID SECONDARY

- Upon confirmation, the claim will adjudicate and the claim ID will populate.
- The claim ID will start with 23, which means the claim is a web claim with attachments.
- The status of the claim is **Suspended** because the primary EOB documents need to be reviewed.



Oklahoma  
HealthCare  
Authority

[My Home](#) [Eligibility](#) [Claims](#) [Prior Authorizations](#) [Referrals](#) [Files Exchange](#) [Financial](#) [Letters](#) [Reports](#) [Resources](#)

[Search Claims](#) | [Submit Claim Dental](#) | [Submit Claim Inst](#) | [Submit Claim Prof](#) | [Submit Claim Pharm](#) | [Search Payment History](#)

[Contact Us](#) | [Logout](#)

[Claims](#) > Claim Receipt

**Submit Outpatient Claim: Confirmation** ?

**Outpatient Claim Receipt**

Your Outpatient Claim was successfully submitted. The claim status is Suspended.

The Claim ID is 23XXXXXXXXXX.

Click **Print Preview** to view the claim details as they have been saved by the agency.

Click **Edit** to resubmit the claim.

Click **View** to view the details of the submitted claim.

[Print Preview](#) [Edit](#) [New](#) [View](#)

# HMO CO-PAY

- Medicaid is considered secondary when the patient has a private Health Maintenance Organization (HMO) plan.
- OHCA reimburses providers for co-payments and services not covered by commercial plans under a cap arrangement.
  - 1500 Professional - \$200
  - UB-04 - \$1,000

# HMO CO-PAY

- HMO co-pay claims submitted through the OHCA secure provider portal will begin with a region code of 94.
- All HMO co-pay claims must have the primary EOB attached.
- The co-pay amount should only be billed as one line item of service.

# HMO CO-PAY

**Submit Institutional Claim: Step 1** ?

\* Indicates a required field.

Claim Type

HCA-17

Choose the appropriate Claim Type.

# HMO CO-PAY

Attending, Operating and Referring Providers are individual provider identifications and are required if applicable.

- **Operating Provider** is required when billing a surgical procedure.

Enter the **Member ID** number. The member demographics will auto populate if the ID is valid.

| Provider Information  |                      |                   |                           |
|---|----------------------|-------------------|---------------------------|
| If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required. |                      |                   |                           |
| <b>Billing Provider ID</b>  | <b>ID Type</b>       | <b>NPI</b>        | <b>Name</b>               |
| <b>Zip Code</b>   | <b>Contract Code</b> | <b>Taxonomy</b>   | <b>SC Provider Number</b> |
| <b>Institutional Provider ID</b>  | <input type="text"/> | <b>ID Type</b>    | <input type="text"/>      |
| <b>Attending Provider ID</b>  | <input type="text"/> | <b>ID Type</b>    | <input type="text"/>      |
| <b>Operating Provider ID</b>  | <input type="text"/> | <b>ID Type</b>    | <input type="text"/>      |
| <b>Referring Provider ID</b>  | <input type="text"/> | <b>ID Type</b>    | <input type="text"/>      |
| Patient Information   |                      |                   |                           |
| Enter the Member ID. If Member ID is valid, the rest of the member information will populate.           |                      |                   |                           |
| <b>*Member ID</b>   | <input type="text"/> |                   |                           |
| <b>Last Name</b>  |                      | <b>First Name</b> | <b>Middle</b>             |
| <b>Birth Date</b>   |                      |                   |                           |

# HMO CO-PAY

- Enter the required Claim Information.
- Leave Other Insurance at *None*.
- Change HMO Copay to *Yes*.
- Select **Continue** to enter diagnosis.
- **Diagnosis Code** field is required. Enter the diagnosis code without the decimal point and select the **Add** button after each diagnosis.

**Claim Information**

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

\*Covered Dates  - \*

Admission Date/Hour  (hh:mm)

Admission Type

Admitting ICD Version

Patient Status

Patient Account Number

HMO Copay

Covered Days

Discharge Hour  (hh:mm)

Admission Source

Admitting Diagnosis

\*Type of Bill

Other Insurance

Total Charged Amount \$0.00

 **Continue** **Cancel**

**Diagnosis Codes**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| #        | ICD Version   | Diagnosis Code                       | Action |
|----------|---|--------------------------------------|--------|
| <u>1</u> |   |                                      |        |
| 1        | *ICD Version <input type="text" value="ICD-10-CM"/> | *Diagnosis Code <input type="text"/> |        |

 **Add** **Reset**

**Emergency Diagnosis Code**

Only one emergency diagnosis code is allowed per claim.

ICD Version  Diagnosis Code

# HMO CO-PAY

Condition Codes, Occurrence Codes and Value Codes are only required if applicable.

- **Condition code** may describe conditions or circumstances surrounding the reason the patient is in a facility.
- **Occurrence code** identifies significant events relating to an institutional claim or encounter record that may affect payer processing. This code is associated with a specific date.
- **Value code** indicates a monetary condition which was used by the intermediary to process an institutional claim. Value Code dollar amount should include cents.

### Condition Codes

Click the **Remove** link to remove the entire row.

| #   | Condition Code                       | Action |
|---|--------------------------------------|--------|
| 1   |                                      |        |
| 1   | *Condition Code <input type="text"/> |        |
|  <input type="button" value="Add"/> <input type="button" value="Reset"/> |                                      |        |

### Occurrence Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| #   | Occurrence Code                       | From Date                       | To Date                      | Action |
|---|---------------------------------------|---------------------------------|------------------------------|--------|
| 1   |                                       | -                               | -                            |        |
| 1   | *Occurrence Code <input type="text"/> | *From Date <input type="text"/> | To Date <input type="text"/> |        |
|  <input type="button" value="Add"/> <input type="button" value="Reset"/> |                                       |                                 |                              |        |

### Value Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| #   | Value Code                       | Amount                       | Action |
|---|----------------------------------|------------------------------|--------|
| 1   |                                  |                              |        |
| 1   | *Value Code <input type="text"/> | *Amount <input type="text"/> |        |
|  <input type="button" value="Add"/> <input type="button" value="Reset"/> |                                  |                              |        |

# HMO CO-PAY

- Enter the appropriate Revenue Code.
- Enter From and To dates.
- Enter the appropriate Units.
- The Charge Amount should be the copay amount only, and must be entered, or claim will deny or pay at \$0.
- There should only be one line item with a payable code.
- Add service details.

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| Svc # | Revenue Code | HCPCS/Proc Code | From Date | To Date | Units | Charge Amount | Action |
|-------|--------------|-----------------|-----------|---------|-------|---------------|--------|
| 1     |              |                 |           |         |       |               |        |

1 \*Revenue Code  HCPCS/Proc Code

Modifiers

\*From Date  \*To Date  \*Units  \*Unit Type

Charge Amount

NDC for Item 1



# HMO CO-PAY

**Attachments**

Click the **Remove** link to remove the entire row.

| # | Transmission Method | File | Control # | Attachment Type | Action |
|---|---------------------|------|-----------|-----------------|--------|
|---|---------------------|------|-----------|-----------------|--------|

Click to collapse.

**\*Transmission Method** FT-File Transfer ▾

**\*Upload File**  Browse...

**\*Attachment Type**  ▾

**Description**





The EOB must be attached after entering the service detail lines.

- Click the + icon to expand the **Attachments** section.
- Choose the **Attachment Type** and **Add** the attachment.
- Select **Submit** after all lines of service and attachments have been entered.

# HMO CO-PAY

| Service Details   |                                   |                 |     |            |            |            |               |
|-------------------|-----------------------------------|-----------------|-----|------------|------------|------------|---------------|
| Svc #             | Revenue Code                      | HCPCS/Proc Code | Mod | From Date  | To Date    | Units/Type | Charge Amount |
| <a href="#">1</a> | 424-PHYSICAL THERAPY/EVAL/RE-EVAL |                 |     | 12/08/2020 | 12/08/2020 | 1.00 Unit  | \$150.00      |

| Attachments       |                     |                |                |                            |
|-------------------|---------------------|----------------|----------------|----------------------------|
| #                 | Transmission Method | File           | Control #      | Attachment Type            |
| <a href="#">1</a> | FT-File Transfer    | Sample EOB.pdf | 20210108635341 | EB-Explanation of Benefits |

No Emergency Diagnosis Code exist for this claim

No Other Insurance Details exist for this claim

No Condition Codes exist for this claim

No Occurrence Codes exist for this claim

No Value Codes exist for this claim

No Surgical Procedures exist for this claim

[Back to Step 1](#) | [Back to Step 2](#) | [Back to Step 3](#) | [Print Preview](#) |  [Confirm](#) | [Cancel](#)

- Review the claim to verify the information was entered correctly.
- Information can be changed by selecting **Back to Step 1, 2 or 3**.
- Select **Confirm** to finalize the claim.

# HMO CO-PAY

- Upon confirmation, the claim will adjudicate and claim ID will populate.
- HMO web claim IDs begin with 94.
- This claim is **Suspended** because the documents uploaded need to be reviewed.

Oklahoma HealthCare Authority

[My Home](#) [Eligibility](#) [Claims](#) [Prior Authorizations](#) [Referrals](#) [Files Exchange](#) [Financial](#) [Letters](#) [Reports](#) [Resources](#)

[Search Claims](#) | [Submit Claim Dental](#) | [Submit Claim Inst](#) | [Submit Claim Prof](#) | [Submit Claim Pharm](#) | [Search Payment History](#)

[Contact Us](#) | [Logout](#)

[Claims](#) > Claim Receipt

**Submit Outpatient Claim: Confirmation** ?

**Outpatient Claim Receipt**

Your Outpatient Claim was successfully submitted. The claim status is Suspended.

The Claim ID is 94XXXXXXXXXX.

Click **Print Preview** to view the claim details as they have been saved by the agency.

Click **Edit** to resubmit the claim.

Click **View** to view the details of the submitted claim.

[Print Preview](#) [Edit](#) [New](#) [View](#)

# MEDICARE CROSSOVER

- Members who have Medicare as primary and Medicaid as secondary are considered dual eligible.
- Providers must be in network with Medicare and Medicaid for OHCA to pay as secondary.
- A claim must be submitted to Medicare prior to submitting a claim to OHCA for reimbursement.

# MEDICARE CROSSOVER

- OHCA reimburses the coinsurance and deductible of Medicare up to a certain percentage.
- The claim must be submitted as a crossover inpatient or crossover outpatient.
- Medicare coinsurance, deductible and paid date must be reported under the Crossover Details section of the claim.
  - The Explanation of Medicare Benefits (EOMB) is not required when the Medicare payment is reported.
  - The HCA-28B is not required.

# MEDICARE CROSSOVER

Effective Nov. 1, 2020, claims for dual eligible members who also have a Medicare Part C HMO policy are no longer filed as an HMO co-pay claim (region 92/94).

- These claims will need to be filed as a crossover.
- With this change, HMO claims will pay the same percentage of coinsurance and deductible Part C PPO claims currently pay.

# MEDICARE CROSSOVER

**Submit Institutional Claim: Step 1** ?

\* Indicates a required field.

Claim Type

HCA-17

Two types of Medicare Crossover Claims:

- Crossover Inpatient
- Crossover Outpatient

Choose the appropriate Claim Type.

# MEDICARE CROSSOVER

Attending, Operating and Referring Providers are individual provider identifications and are required if applicable.

- Operating Provider is required when billing a surgical procedure.

Enter the Member ID number. The member demographics will auto populate if the ID is valid.

| Provider Information  |                      |            |                      |
|---|----------------------|------------|----------------------|
| If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required. |                      |            |                      |
| Billing Provider ID   | ID Type              | NPI        | Name                 |
| Zip Code  | Contract Code        | Taxonomy   | SC Provider Number   |
| Institutional Provider ID   | <input type="text"/> | ID Type    | <input type="text"/> |
| Attending Provider ID   | <input type="text"/> | ID Type    | <input type="text"/> |
| Operating Provider ID   | <input type="text"/> | ID Type    | <input type="text"/> |
| Referring Provider ID   | <input type="text"/> | ID Type    | <input type="text"/> |
| Patient Information   |                      |            |                      |
| Enter the Member ID. If Member ID is valid, the rest of the member information will populate.           |                      |            |                      |
| *Member ID  | <input type="text"/> |            |                      |
| Last Name   |                      | First Name | Middle               |
| Birth Date  |                      |            |                      |

# MEDICARE CROSSOVER

- Enter the required Claim Information.
- Leave Other Insurance at *None*.
- Diagnosis Code field is required. Enter the diagnosis code without the decimal point and select the **Add** button after each diagnosis.

**Claim Information**

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

\*Covered Dates  -

Admission Date/Hour  (hh:mm)

Admission Type

Admitting ICD Version

Patient Status

Patient Account Number

Covered Days

Discharge Hour  (hh:mm)

Admission Source

Admitting Diagnosis

\*Type of Bill

Other Insurance

Total Charged Amount \$ 0.00



**Diagnosis Codes**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| #        | ICD Version   | Diagnosis Code                       | Action |
|----------|---|--------------------------------------|--------|
| <u>1</u> |   |                                      |        |
| 1        | *ICD Version <input type="text" value="ICD-10-CM"/> | *Diagnosis Code <input type="text"/> |        |



**Emergency Diagnosis Code**

Only one emergency diagnosis code is allowed per claim.

ICD Version  Diagnosis Code

# MEDICARE CROSSOVER

Condition Codes, Occurrence Codes and Value Codes are only required if applicable.

- **Condition code** may describe conditions or circumstances surrounding the reason the patient is in a facility.
- **Occurrence code** identifies significant events relating to an institutional claim or encounter record that may affect payer processing. This code is associated with a specific date.
- **Value code** indicates a monetary condition which was used by the intermediary to process an institutional claim. Value Code dollar amount should include cents.

### Condition Codes

Click the **Remove** link to remove the entire row.

| # | Condition Code  | Action |
|---|---|--------|
| 1 |   |        |
| 1 | *Condition Code <input type="text"/>  |        |
|   |  <input type="button" value="Add"/> <input type="button" value="Reset"/> |        |

### Occurrence Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| # | Occurrence Code   | From Date                       | To Date                      | Action |
|---|---|---------------------------------|------------------------------|--------|
| 1 |   | -                               | -                            |        |
| 1 | *Occurrence Code <input type="text"/>   | *From Date <input type="text"/> | To Date <input type="text"/> |        |
|   |  <input type="button" value="Add"/> <input type="button" value="Reset"/> |                                 |                              |        |

### Value Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| # | Value Code  | Amount                       | Action |
|---|---|------------------------------|--------|
| 1 |   |                              |        |
| 1 | *Value Code <input type="text"/>  | *Amount <input type="text"/> |        |
|   |  <input type="button" value="Add"/> <input type="button" value="Reset"/> |                              |        |

# MEDICARE CROSSOVER

- Reference the Medicare EOB for the Crossover Details.
- This is broken down per line item.
- **Add** service details.
- It is not necessary to attach the EOB from Medicare.
- Select **Submit** after all lines of service have been entered.

### Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| Svc #             | Revenue Code                      | HCPCS/Proc Code | From Date  | To Date    | Units     | Charge Amount | Action                 |
|-------------------|-----------------------------------|-----------------|------------|------------|-----------|---------------|------------------------|
| <a href="#">1</a> | 424-PHYSICAL THERAPY/EVAL/RE-EVAL |                 | 12/08/2020 | 12/08/2020 | 1.00 Unit | \$150.00      | <a href="#">Remove</a> |
| 2                 |                                   |                 |            |            |           |               |                        |

2 \*Revenue Code  HCPCS/Proc Code

Modifiers

\*From Date  \*To Date  \*Units  \*Unit Type

Charge Amount

NDC for Item 2

#### Medicare Crossover Details for Item 2

Medicare Crossover Details must be entered in this step if the Covered From Date is on or after 01/01/2016.

|                         |                                     |                       |                                     |
|-------------------------|-------------------------------------|-----------------------|-------------------------------------|
| Deductible Amount       | <input type="text" value="\$0.00"/> | Co-insurance Amount   | <input type="text" value="\$0.00"/> |
| Blood Deductible Amount | <input type="text" value="\$0.00"/> | Medicare Payment Date | <input type="text"/>                |
| Medicare Payment Amount | <input type="text" value="\$0.00"/> |                       |                                     |



Attachments



# MEDICARE CROSSOVER

- Review the claim to verify the information was entered correctly.
- Information can be changed by selecting **Back to Step 1, 2 or 3**.
- Select **Confirm** to finalize the claim.

| Diagnosis Codes <span style="float: right;">+</span>   |                                   |                 |     |            |            |            |               |
|--|-----------------------------------|-----------------|-----|------------|------------|------------|---------------|
| Service Details <span style="float: right;">-</span>   |                                   |                 |     |            |            |            |               |
| Svc #  | Revenue Code                      | HCPCS/Proc Code | Mod | From Date  | To Date    | Units/Type | Charge Amount |
| 1  | 424-PHYSICAL THERAPY/EVAL/RE-EVAL |                 |     | 12/08/2020 | 12/08/2020 | 1.00 Unit  | \$150.00      |
| No Emergency Diagnosis Code exist for this claim   |                                   |                 |     |            |            |            |               |
| No Other Insurance Details exist for this claim  |                                   |                 |     |            |            |            |               |
| No Condition Codes exist for this claim  |                                   |                 |     |            |            |            |               |
| No Occurrence Codes exist for this claim   |                                   |                 |     |            |            |            |               |
| No Value Codes exist for this claim  |                                   |                 |     |            |            |            |               |
| No Surgical Procedures exist for this claim  |                                   |                 |     |            |            |            |               |
| No Attachments exist for this claim  |                                   |                 |     |            |            |            |               |
| <span>Back to Step 1</span> <span>Back to Step 2</span> <span>Back to Step 3</span> <span>Print Preview</span> <span style="color: red; font-size: 2em;">➔</span> <span>Confirm</span> <span>Cancel</span> |                                   |                 |     |            |            |            |               |

# MEDICARE CROSSOVER

- Upon confirmation the claim will adjudicate and claim ID will populate.
- Claim ID beginning with 22 region code indicates an internet claim with no attachments.

The screenshot displays the Oklahoma HealthCare Authority website interface. At the top, the logo for Oklahoma HealthCare Authority is visible. Below the logo is a navigation menu with links for My Home, Eligibility, Claims, Prior Authorizations, Referrals, Files Exchange, Financial, Letters, Reports, and Resources. A search bar is located below the navigation menu, with the text "Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Submit Claim Pharm | Search Payment History".

The main content area shows a breadcrumb trail: [Claims](#) > Claim Receipt. There are links for [Contact Us](#) and [Logout](#) in the top right corner.

The central focus is a confirmation message titled "Submit Crossover Outpatient Claim: Confirmation". The message states: "Your Crossover Outpatient Claim was successfully submitted. The claim status is Paid. The Claim ID is 22XXXXXXXXXX." Below this message, there are instructions: "Click **Print Preview** to view the claim details as they have been saved by the agency. Click **Edit** to resubmit the claim. Click **View** to view the details of the submitted claim." At the bottom of the message box, there are four buttons: **Print Preview**, **Edit**, **New**, and **View**.

# CLAIM FUNCTIONS

# SEARCH CLAIMS

Claims may be searched by:

- Claim ID
- Member ID
- Service From and To dates (auto-populates with last 90-day range).

### Search Claims ?

Medical/Dental Pharmacy

A minimum one field is required.  
Either 'Paid Date' or 'Service From' and 'To' Date are required fields for the search when Claim ID is not entered.

**Claim Information**

Claim ID

**Member Information**

Member ID

**Service Information**

Service From   To   Claim Type

Paid Date   Claim Status

# SEARCH CLAIMS

| Search Results  |                               |                           |                     |                       |                  |                            |                      |                             |                  |
|---|-------------------------------|---------------------------|---------------------|-----------------------|------------------|----------------------------|----------------------|-----------------------------|------------------|
| To see additional claim information, or view a remittance advice, click on the '+' next to the Claim ID. To view the entire claim, click on the Claim ID. |                               |                           |                     |                       |                  |                            |                      |                             |                  |
| Total Records: 6  |                               |                           |                     |                       |                  |                            |                      |                             |                  |
|   | <u>Claim ID</u>               | <u>Claim Type</u>         | <u>Claim Status</u> | <u>Service Date</u> ▼ | <u>Member ID</u> | <u>Patient Acct Number</u> | <u>Billed Amount</u> | <u>Medicaid Paid Amount</u> | <u>Paid Date</u> |
| +   | <a href="#">2220xxxxxxxxx</a> | Professional              | Paid                | 11/06/2020            |                  |                            | \$120.00             | \$66.86                     | –                |
| +   | <a href="#">2320xxxxxxxxx</a> | Professional              | Denied              | 11/02/2020            |                  |                            | \$170.00             | \$0.00                      | –                |
| +   | <a href="#">2320xxxxxxxxx</a> | Professional              | Denied              | 11/02/2020            |                  |                            | \$120.00             | \$0.00                      | –                |
| +   | <a href="#">9420xxxxxxxxx</a> | Professional              | Denied              | 11/02/2020            |                  |                            | \$60.00              | \$0.00                      | –                |
| +   | <a href="#">2220xxxxxxxxx</a> | Crossover<br>Professional | Denied              | 11/02/2020            |                  |                            | \$120.00             | \$0.00                      | –                |
| +   | <a href="#">2320xxxxxxxxx</a> | Professional              | Denied              | 11/02/2020            |                  |                            | \$120.00             | \$0.00                      | –                |

Click on the blue Claim ID hyperlink to view the claim.

# PAID CLAIM FUNCTIONS

Claims in a paid status allows the user to Copy or Void.

### Claim Information

|                        |            |                        |            |
|------------------------|------------|------------------------|------------|
| Claim Status           | Paid       | Paid Date              | 12/08/2020 |
| Date Type              | _          | Date of Current        | _          |
| Accident Related       | _          | Expected Delivery Date | _          |
| Patient Account Number | _          | To Date                | 11/06/2020 |
| From Date              | 11/06/2020 | HMO Copay              | No         |
| CLIA Number            | _          | Total Charged Amount   | \$120.00   |
| Related Claim ICN      | _          | Total Co-pay Amount    | \$0.00     |
|                        |            | Total Allowed Amount   | \$66.86    |
|                        |            | Total Paid Amount      | \$66.86    |

[Expand All](#) | [Collapse All](#)

### Adjudication Errors

[+](#)

### Diagnosis Codes

[+](#)

### Service Details

[-](#)

| Svc #                     | From Date  | To Date    | Place of Service | EMG | Procedure Code | Mod | Diag Code Ptrs | Units     | EPSDT | Charge Amount | Allowed Amount | Co-pay Amount |
|---------------------------|------------|------------|------------------|-----|----------------|-----|----------------|-----------|-------|---------------|----------------|---------------|
| <a href="#">1</a><br>Paid | 11/06/2020 | 11/06/2020 | 11               | N   | 99213          |     | 1              | 1.00 Unit |       | \$120.00      | \$66.86        | \$0.00        |

No Other Insurance Details exist for this claim

No Attachments exist for this claim

[Copy](#) [Void](#) [Print Preview](#) [RA Copy](#)

# PAID CLAIM FUNCTIONS

- Copy options for paid claims:
  - Member Information
  - Service Information
  - Member Information and Service Information
  - Entire Claim
- Claims voided after six months from the date of service are subject to timely filing limitations.
- Claims nearing the timely filing limitation should not be voided without instruction from OHCA.

# PAID CLAIM FUNCTIONS

## Copy claim:

- Select the information to copy.

### Copy Professional Claim ?

Select the information you would like to have copied to the new claim. Press Copy to initiate the claim and continue entering claim information.

|   |  |   |   |
|---|--|---|---|
| <input type="radio"/> <b>Member Information</b> | <input type="radio"/> <b>Service Information</b> | <input type="radio"/> <b>Member and Service Information</b> | <input type="radio"/> <b>Entire Claim</b>   |
| Member ID                                       | Service Facility Location                        | Copies data listed in previous 2 columns.                   | Copies data listed in columns 1 and 2 PLUS: |
| Member Count                                    | Diagnosis Code(s)                                |   | Referring Provider                          |
| Last Name                                       | Place(s) of Service                              |   | Ordering Provider                           |
| First Name                                      | Procedure Code(s)                                |   | Other Facility                              |
| Birth Date                                      | Modifier(s)                                      |   | Accident Related                            |
| Patient Account Number                          | Diagnosis Pointer(s)                             |   | Pregnancy Indicator                         |
|   | Detail Charge Amount(s)                          |   | Emergency Indicator(s)                      |
|   | Units  |   | Claim CLIA Number(s)                        |
|   | Unit Type(s)                                     |   | Other Insurance                             |
|   | EPSDT  |   | HMO Copay                                   |
|   | Service Details CLIA Number(s)                   |   | All Dates                                   |
|   | DMH Contract Source(s)                           |   |   |
|   | Rendering Provider(s)                            |   |   |
|   | SC Provider(s)                                   |   |   |
|   | Ordering Provider(s)                             |   |   |
|   | NDC Code Type(s)                                 |   |   |
|   | NDC Code(s)                                      |   |   |
|   | NDC Quantity(s)                                  |   |   |
|   | NDC Unit of Measure(s)                           |   |   |

 **Copy** **Cancel**

# PAID CLAIM FUNCTIONS

|                             |     |       |  |  |  |  |            |        |        |
|-----------------------------|-----|-------|--|--|--|--|------------|--------|--------|
| <a href="#">4</a><br>Denied | 306 | 87804 |  |  |  |  | \$92.06    | \$0.00 | \$0.00 |
| <a href="#">5</a><br>Paid   | 450 | 99283 |  |  |  |  | \$1,550.85 | \$9.97 | \$0.00 |
| <a href="#">6</a><br>Denied | 637 | A9270 |  |  |  |  | \$15.41    | \$0.00 | \$0.00 |

**Confirmation** ✕

**Are you sure you want to void this Crossover Outpatient Claim ID 2020XXXXXXXXXX.**



No Emergency Diagnosis Code exist for this claim

No Other Insurance Details exist for this claim

No Value Codes exist for this claim

No Surgical Procedures exist for this claim

No Attachments exist for this claim

Void claim:

- Select OK to confirm.

# DENIED CLAIM FUNCTIONS

Claims can be denied either at the header or detail levels.

- **Header:** Contains information about the member and provider but not about the services performed.
  - The system will verify member's eligibility and provider's contract information, causing the entire claim to deny.
- **Detail:** Contains information specific to the services performed.
  - The system verifies coverage of services, policy limitations or program restrictions which will cause specific service lines to deny and not the entire claim.

# DENIED CLAIM FUNCTIONS

- The OHCA secure provider portal provides HIPAA and EOB remark codes for the denial reason.
- Denied claims can be edited for changes and resubmitted through the provider portal.
- Claims in a denied status cannot be voided.

# DENIED CLAIM FUNCTIONS

Claims in a denied status allows the user to view Adjudication Errors or Edit the claim.



The screenshot displays a web interface for a denied claim. At the top, there is a header bar with the text "Adjudication Errors" and a red arrow pointing to a plus sign icon. Below this is a section for "Diagnosis Codes" with a plus sign icon. A message states "Other Insurance was denied for this claim." The main section is titled "Service Details" and contains a table with the following columns: Svc #, Revenue Code, HCPCS/Proc Code, Mod, From Date, To Date, Units/Type, Charge Amount, Allowed Amount, and Co-pay Amount. The table has one row with the following data: Svc # (1 Denied), Revenue Code (490), HCPCS/Proc Code (empty), Mod (empty), From Date (12/17/2020), To Date (12/18/2020), Units/Type (2.00 Unit), Charge Amount (\$0.00), Allowed Amount (\$0.00), and Co-pay Amount (\$0.00). Below the table, there are several messages: "No Emergency Diagnosis Code exist for this claim", "No Condition Codes exist for this claim", "No Occurrence Codes exist for this claim", "No Value Codes exist for this claim", "No Surgical Procedures exist for this claim", and "No Attachments exist for this claim". At the bottom, there is a red arrow pointing to an "Edit" button and a "Print Preview" button.

| Svc #       | Revenue Code | HCPCS/Proc Code | Mod | From Date  | To Date    | Units/Type | Charge Amount | Allowed Amount | Co-pay Amount |
|-------------|--------------|-----------------|-----|------------|------------|------------|---------------|----------------|---------------|
| 1<br>Denied | 490          |                 |     | 12/17/2020 | 12/18/2020 | 2.00 Unit  | \$0.00        | \$0.00         | \$0.00        |

# DENIED CLAIM FUNCTIONS

| Adjudication Errors  |              |                 |     |            |            |            |               |                |               |
|---|--------------|-----------------|-----|------------|------------|------------|---------------|----------------|---------------|
| Diagnosis Codes      |              |                 |     |            |            |            |               |                |               |
| Other Insurance was denied for this claim.  |              |                 |     |            |            |            |               |                |               |
| Service Details      |              |                 |     |            |            |            |               |                |               |
| Svc #   | Revenue Code | HCPCS/Proc Code | Mod | From Date  | To Date    | Units/Type | Charge Amount | Allowed Amount | Co-pay Amount |
| <u>1</u><br>Denied  | 490          |                 |     | 12/17/2020 | 12/18/2020 | 2.00 Unit  | \$0.00        | \$0.00         | \$0.00        |

Click the + sign on the Adjudication Errors bar to view the denial reasons.

# DENIED CLAIM FUNCTIONS

| Adjudication Errors |           |                          |                  |  |      |   |
|---------------------|-----------|--------------------------|------------------|--|------|---|
| Claim / Service #   | HIPAA Adj | Description              | HIPAA Adj Remark | Description  | EOB  | Description   |
| Service # 1         | A1        | Claim denied charges.    | N115             | This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at <a href="http://www.cms.gov/mcd">www.cms.gov/mcd</a> , or if you do not have web access, you may contact the contractor to request a copy | 9998 | CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO |
| Service # 1         | 18        | Duplicate claim/service. | N109             | This claim was chosen for complex review and was denied after reviewing the medical records.   | 4318 | PROCEDURE DENIED DUE TO NEW VISIT FREQUENCY                                     |

The EOB description remarks provide a more detailed explanation of why the claim denied.

# DENIED CLAIM FUNCTIONS

**Adjudication Errors** +

**Diagnosis Codes** +

**Other Insurance was denied for this claim.**

**Service Details** -

| Svc #              | Revenue Code | HCPCS/Proc Code | Mod | From Date  | To Date    | Units/Type | Charge Amount | Allowed Amount | Co-pay Amount |
|--------------------|--------------|-----------------|-----|------------|------------|------------|---------------|----------------|---------------|
| <u>1</u><br>Denied | 490          |                 |     | 12/17/2020 | 12/18/2020 | 2.00 Unit  | \$0.00        | \$0.00         | \$0.00        |

**No Emergency Diagnosis Code exist for this claim**

**No Condition Codes exist for this claim**

**No Occurrence Codes exist for this claim**

**No Value Codes exist for this claim**

**No Surgical Procedures exist for this claim**

**No Attachments exist for this claim**

 **Edit** **Print Preview**

Select **Edit** to modify the claim.

# DENIED CLAIM FUNCTIONS

**Adjudication Errors** +

**Service Details** -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

| Svc #             | Revenue Code                 | HCPCS/Proc Code | From Date  | To Date    | Units     | Charge Amount | Action |
|-------------------|------------------------------|-----------------|------------|------------|-----------|---------------|--------|
| <a href="#">1</a> | 490-AMBULATORY SURGICAL CARE |                 | 12/17/2020 | 12/18/2020 | 2.00 Unit |               |        |
| 2                 |                              |                 |            |            |           |               |        |

2 **\*Revenue Code**  **HCPCS/Proc Code**

**Modifiers**

**\*From Date**   **\*To Date**   **\*Units**  **\*Unit Type**

**Charge Amount**

**NDC for Item 2** +

**Attachments** -

Click the **Remove** link to remove the entire row.

| #                          | Transmission Method | File | Control # | Attachment Type | Action |
|----------------------------|---------------------|------|-----------|-----------------|--------|
| + Click to add attachment. |                     |      |           |                 |        |



Click Resubmit once all edits are saved.

# RESOURCES

# HELPFUL TELEPHONE NUMBERS

- OHCA call center
  - 800-522-0114 or 405-522-6205; option 1
- Internet help desk
  - 800-522-0114 or 405-522-6205; option 2, 1
- EDI help desk
  - 800-522-0114 or 405-522-6205; option 2, 2

# HELPFUL LINKS

- NEW agency website
  - <https://oklahoma.gov/ohca>
- Coronavirus information
  - <https://oklahoma.gov/ohca/about/covid19/coronavirus.html>
- Managed care
  - <https://oklahoma.gov/ohca/about/medicaid-expansion/soonerselect.html>
- Telehealth services
  - <https://oklahoma.gov/ohca/providers/telehealth.html>
- OHCA provider portal
  - [www.ohcaprovider.com](http://www.ohcaprovider.com)

# HELPFUL LINKS

Provider training:

- Upcoming webinar trainings
- Previous training materials
- Recorded webinars
- How-to videos
- Resources

Visit at

[https://oklahoma.gov/ohca/providers/provider-training.](https://oklahoma.gov/ohca/providers/provider-training)

# PROVIDER VISITS

A telephonic or virtual visit with a provider education specialist may be requested for specific training on a topic.

Providers may contact the SoonerCare coordinator to request assistance from a provider education specialist by emailing [SoonerCareEducation@okhca.org](mailto:SoonerCareEducation@okhca.org).

# PROVIDER VISITS

To assist the provider education specialists in planning and structuring the visit or group training, the following information is needed:

- Provider type attending the training
- Number of attendees
- Time and location requested
- Issues to be addressed
- Point of contact, if additional information is needed prior to the event

# POLICY AND RULES

OHCA policy and rules:

- <https://oklahoma.gov/ohca/policies-and-rules/xpolicy.html>.
- Provider policies and rules and Oklahoma Health Care Authority Medicaid rules.
  - Chapter 25 – SoonerCare Choice.
  - Chapter 30 – Fee for Service.

**QUESTIONS?**



**OKLAHOMA**  
Health Care Authority

## GET IN TOUCH

4345 N. Lincoln Blvd.  
Oklahoma City, OK 73105

[oklahoma.gov/ohca](http://oklahoma.gov/ohca)  
[mysoonercare.org](http://mysoonercare.org)

Agency: 405-522-7300  
Helpline: 800-987-7767

